MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
Communicable Disease and Immunization Division
GASTROINTESTINAL ILLNESS CASE INVESTIGATION

(Please check disease investigated)

___ Amebiasis ___ Cryptosporidiosis ___ Listeriosis Other_____

___ *Campylobacter* ___ *E. coli* 0157: H7(toxin producing) ___ Salmonellosis **Identify if Outbreak Related:** _____

___ Cyclosporiasis ___ Giardiasis ___ Shigellosis

CASE IDENTIFYING INFORMATION

Case Name:_____ Age or Birthdate: _____ Sex: ___ Race:_____

Address:_____ Home phone:_____
(Street) (City) (**County**) (Zip) Work phone:_____

Occupation:_____ Location:_____
(If infant or student, list school or daycare)

Attending Physician: _____ Address & Phone_____

Patient Hospitalized: **Y or N** Hospital:_____

(Admission date) _____ (Discharge date) _____ (City)

HIGH RISK POTENTIAL: Y or N (If Yes, Please circle below)

Contact to confirmed case Contact to suspected case Daycare attendee Food Handler Other_____
Direct patient care worker Resident of institutional facility Daycare worker Animal handler

DATE OF SYMPTOM ONSET: _____ **DATE RECOVERED:** _____

SYMPTOMS: (Circle all that apply) **No Symptoms** ____

Abdominal Pain Diarrhea Chills Fever ___ E F/C Nausea Other_____
Body Ache Diarrhea w/blood Fatigue Headache Vomiting

SPECIMEN COLLECTED: Blood Stool Urine Other _____

LAB RESULT: _____ **LAB NAME:** _____

TRAVEL (in/out of state or international) in the past month? **Y or N** Location/date:_____

SWIMMING in the past month? **Y or N** Location/date: _____

DRINKING WATER SOURCE: (Circle all that apply) **ANIMAL CONTACTS:** _____

Home: Municipal Well Bottled
Work: Municipal Well Bottled

LIST ALL CONTACTS WITH CONCURRENT OR SIMILAR ILLNESS (list additional info in comment section)

NAME	DATE OF ONSET	ADDRESS & PHONE	RELATION-SHIP	Describe HIGH RISK factors
1.				
2.				
3.				
4.				

Name of person interviewed and relationship to case: _____ **Date** _____

Person completing form _____ **Health Dept.** _____

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LIST ALL PLACES WHERE YOU PURCHASED FOOD IN THE 2 WEEKS PRIOR TO ILLNESS ONSET:
(*Include*: Grocery Stores, Markets, Produce Stands, Convenience Stores, Home Delivery)

DATE	NAME	LOCATION	FOOD PURCHASED

LIST ANY OTHER FOOD CONSUMED <u>OUTSIDE</u> THE HOME 2 WEEKS PRIOR TO ILLNESS ONSET:
(Include: Carry out, Convenience Stores, Events, Fast Food, Parties, Restaurants, Travel or Work-Related Meals)

DATE	NAME	FOOD CONSUMED	LOCATION/EVENT

3 DAY FOOD HISTORY: List all foods/beverages 3 days <u>prior</u> to onset (Prompt for typical foods if unable to recall)

Day/Date	**Day/Date**	**Day/Date**
Breakfast: Location:	Breakfast: Location:	Breakfast: Location:
Lunch : Location:	Lunch : Location:	Lunch: Location:
Dinner: Location:	Dinner: Location:	Dinner: Location:
Other/snacks:	Other/snacks:	Other/snacks:

COMMENTS(Attach extra sheet if needed):